PRINTED: 04/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157580	B. WIN	G		03/3	0/2012
	OVIDER OR SUPPLIER THE HEALTH CARE	EINCORPORATED		25	EET ADDRESS, CITY, STATE, ZIP CODE 588 PORTAGE MALL ORTAGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		G	000			
	recertification survey extended survey.						
	Facility #: IN 011167 Medicaid Vendor #:						
	Dates of Survey: Ma	rch 27, 28, 29, and 30, 2012.					
	Surveyor: Janet Brai	ndt, RN,PHNS.					
	Unduplicated Census	s: 183.					
	Number of records re Number of active rec Number of closed rec	ords reviewed: 8.					
	April 4, 2012						
G 243	484.52 EVALUATION PROGRAM	I OF THE AGENCY'S	G:	243			
	evaluation of the age once a year by the gr personnel (or a comm staff, and consumers	policies requiring an overall ncy's total program at least roup of professional nittee of this group), HHA, or by professional people rorking in conjunction with					
	Based on interview a agency failed to ensu	not met as evidenced by: and review of documents, the are an annual evaluation was agency reviewed with the					
ABORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157580	B. WIN	G		03/3	0/2012
	ROVIDER OR SUPPLIER	: INCORPORATED		25	EET ADDRESS, CITY, STATE, ZIP CODE 588 PORTAGE MALL ORTAGE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 243	potential to affect all to a protential to affect all to a protential to affect all to a protential to a program and appropriateness and resolved identified patient care. 2. Employee A, on 3 the quality assurance so Employee D was a program as of last we are a program as of last we are a program. The program and as a program as of last we are a program as of last we are a program as of last we are a program. The program as of last we are a program as of last we are a program as a program as a program as a program as	documents failed to note improvement program. The pole to produce any dence implementation, sessment of a performance in that evaluated the quality of patient care, identified id problems, and improved (30/12 at 1:15 PM, indicated a program had been lacking assigned to take over the eek. 15 PM on 3/30/12, stated, Home Health Aides, and staff to create an eess and will be deciding the measures the agency will the will be performing chart comer satisfaction surveys."		243			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157580	B. WIN			03/3	0/2012
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED				2588	T ADDRESS, CITY, STATE, ZIP CODE B PORTAGE MALL RTAGE, IN 46368	, 33.5	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 244	completed that cons administrative review for 1 of 1 agency re affect all the patients. The findings include 1. Review of agency evidence a performation to evidence a performation to evidence and as improvement program and appropriateness and resolved identification to experience and appropriateness and resolved identification as a program as of last with the experience and appropriateness and resolved identification as a program as of last with the experience and appropriateness and resolved identification appropriateness	isted of a policy and a a clinical record review viewed with the potential to a of the agency. If y documents failed to ance improvement program, able to produce any idence implementation, assessment of a performance of patient care, identified ed problems, and improved If y documents failed to ance improvement program, able to produce any idence implementation, assessment of a performance of patient care, identified ed problems, and improved If y documents failed to ance improvement program, and improved and improved If y documents failed to ance improved and improved and improved If y documents failed to ance improved and improved and improved and improved If y documents failed to ance improvement and improved and improved and improved and improved ance improved and improved ance improved and improved ance im		244			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		157580	B. WIN			03/3	0/2012
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED				:	REET ADDRESS, CITY, STATE, ZIP CODE 2588 PORTAGE MALL PORTAGE, IN 46368	1 00,0	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 245	Continued From page	e 3	G	245	5		
	Based on interview a agency failed to ensure completed that evaluadequacy, effectivent agency's program for with the potential to a agency. The findings include: 1. Review of agency	nce improvement program.					
	documentation to evi maintenance and as improvement prograr and appropriateness	dence implementation, sessment of a performance in that evaluated the quality of patient care, identified ad problems, and improved					
	the quality assurance	/30/12 at 1:15 PM, indicated program had been lacking assigned to take over the eek.					
	"We will be including therapists, and nursir inter-disciplinary proceedings of the program. It is a subject to the program and its as well as custom the produce used for the program.	ng staff to create an creases and will be deciding ty measures the agency will We will be performing chart tomer satisfaction surveys." d a notebook untitled to be					
G 246	484.52 EVALUATION	I OF THE AGENCY'S	G	246	5		

Facility ID: 011167

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		157580	B. WING	B	03	/30/2012	
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIF 2588 PORTAGE MALL PORTAGE, IN 46368	•	70072012	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
	acted upon by thos of the agency. This STANDARD is Based on interview agency failed to encompleted for 1 of potential to affect a The findings included 1. Review of agency was understanding to emaintenance and a simprovement progrand appropriateness and resolved identipatient care. 2. Employee A, on the quality assurance of the program as of last was program as of last was the control of the	uation are reported to and e responsible for the operation s not met as evidenced by: and review of documents, the sure an annual evaluation was 1 agency reviewed with the ll the patients of the agency. e: cy documents failed to ance improvement program. hable to produce any vidence implementation, assessment of a performance am that evaluated the quality is of patient care, identified fied problems, and improved 3/30/12 at 1:15 PM, indicated ce program had been lacking is assigned to take over the	G 2	246			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER THE HEALTH CARE	E INCORPORATED		STREET ADDRESS, CITY, STATE, ZIP C 2588 PORTAGE MALL PORTAGE, IN 46368	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
G 246	Continued From page used for the program		G 2	46			